BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **KING T. LEUNG, M.D.,** Holder of License No. 10262 For the Practice of Allopathic Medicine in the State of Arizona	Docket No. 06A-10262-MDX Case Nos. MD-05-0416A MD-06-0340A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR REVOCATION OF LICENSE.**

On April 11, 2007 this matter came before the Arizona Medical Board ("Board") for oral argument and consideration of the Administrative Law Judge ("ALJ") Daniel G. Martin's proposed Findings of Fact and Conclusions of Law and Recommended Order involving King T. Leung, M.D. ("Respondent"). Respondent was notified of the Board's intent to consider this matter at the Board's public meeting. Respondent did appear and was not represented by counsel. The State was represented by Assistant Attorney General Anne Froedge. Christine Cassetta, Assistant Attorney General with the Solicitor General's Section of the Attorney General's Office provided legal advice to the Board.

The Board having considered the ALJ's recommended decision and the entire record in this matter hereby issues the following Findings of Fact, Conclusion of Law and Order.

Procedural History

The hearing in this matter convened on January 11, 2007 pursuant to a Notice of Hearing issued by the Board on December 21, 2006. Respondent elected not to appear and defend. At the outset of the hearing, the State presented to the ALJ a stipulation and a January 9, 2007 letter it received from Respondent. The stipulation, reached between counsel for the State and counsel for Respondent, is as follows:

A. If Respondent were to testify, he would state he disagrees with the findings and recommendations of the Board's outside medical consultants;

B. Respondent feels the Board investigation was incomplete because no one contacted him before concluding his care was substandard;

C. Respondent has retired from the practice of medicine and will not return to the practice of medicine;

D. Respondent believes his care meets the standard of care; and

E. Respondent's January 9, 2007 letter shall be admitted into evidence as his substantive statement of his defense, it shall not be necessary for Respondent and counsel to appear personally at the hearing, and no inference will rise from Respondent's failure to appear personally at the hearing.

Respondent's January 9, 2007 letter sets forth his substantive response to the Board's allegations of unprofessional conduct. The ALJ accepted Respondent's letter into the Administrative Record and reviewed the contents of the letter. However, the ALJ did not consider Respondent's letter to constitute substantive evidence and gave it no weight in the determination of this matter.

Kelly Sems, M.D., one of the Board's Medical Consultants and Tina Geiser, an assistant manager in the Board's Office of Investigations, appeared and gave testimony at the hearing. That testimony, in combination with the documentary evidence of record, supports the Interim Findings of Fact set forth by the Board in its November 30, 2006 Order for Summary Suspension of License, and the Board adopts those Findings herein.

FINDINGS OF FACT

1. Respondent is the holder of License No. 10262 for the practice of allopathic medicine in the State of Arizona.

2. The Arizona Medical Board (the "Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

Case Number MD-05-0416A

3. The Board initiated case number MD-05-0416A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a sixty year-old female patient ("RR"). RR presented to Respondent on January 26, 1998 complaining of rectal bleeding. Respondent performed a sigmoidoscopy and rectal examination and noted as his only finding internal hemorrhoids. There was no indication in the record that there was retroflexion of the sigmoidoscope. Respondent noted the rectal examination was negative.

4. RR returned to Respondent in August 1999 complaining of recurrent rectal bleeding. Respondent performed a sigmoidoscopy and rectal examination. There was no indication in the record that there was retroflexion of the sigmoidoscope. Respondent did not report any findings. RR returned to Respondent in April 2000 with abdominal distension and lack of bowel movement. Respondent performed a rectal examination that revealed an empty vault. Respondent admitted RR to the hospital. A computed tomography scan of the abdomen demonstrated a possible adrenal mass. A barium enema was negative for an obstructing lesion. RR was discharged to Respondent for outpatient follow-up. On May 10, 2000 Respondent referred RR to a colorectal surgeon for a May 25, 2000 appointment, but RR did not keep the appointment.

5. On May 12, 2000 RR presented to the emergency room where another physician performed a rectal examination that showed a trace of blood and no palpable rectal mass. In September 2000, RR underwent resection of a large rectal carcinoma. RR later developed metastasis and died.

6. The standard of care in evaluating recurrent rectal bleeding requires a physician to look above the reach of the sigmoidoscope using retroflexion. The standard of care also requires a physician to timely refer a patient for a more comprehensive evaluation by a subspecialist.

7. Respondent deviated from the standard of care because he did not look above the reach of the sigmoidoscope using retroflexion and because he did not timely refer RR for a more comprehensive evaluation by a subspecialist.

8. Respondent's failure to look above the reach of the sigmoidoscope using retroflexion and failure to timely refer RR for a more comprehensive evaluation by a subspecialist resulted in his missing a rectal lesion and this delay in diagnosis and treatment led to RR's death.

Case Number MD-06-0340A

9. The Board initiated case number MD-06-0340A after receiving a complaint regarding Respondent's care and treatment of a seventy year-old female patient ("FA"). The Board's Chief Medical Consultant reviewed the complaint.

10. FA was seen by Respondent nine times between January 16, 2006 and April 11, 2006. FA's initial complaint was pulmonary embolism, but Respondent's chart is not clear about what was actually happening with FA. Respondent was attempting to manage warfarin anticoagulation and there was a mention of thrombocytopenia, but Respondent did not note any differential nor was there any discussion in his records.

11. On January 30, 2006 FA had a sub-therapeutic Pro Time International Normalized Ratio ("PT/INR") that Respondent did not address. On February 8, 2006 Respondent diagnosed FA with polyarteritis, but did not provide any explanation of this diagnosis and failed to address the sub-therapeutic PT/INR. On March 1, 2006 Respondent gave FA Celebrex even though she was on warfarin and had thrombocytopenia. On March 3, 2006 FA presented to Respondent with diarrhea and he diagnosed food poisoning. Respondent treated FA with clindamycin – not a known treatment for food poisoning. FA developed a rash and Respondent changed the medication to tetracycline – also not a known treatment for food poisoning. Respondent still did not attend to FA's anti-coagulation issues.

12. On March 6, 2006 Respondent diagnosed FA with colitis, but did not document any supporting discussion or evidence. Respondent also continued to fail to address FA's anti-coagulation issues. Respondent failed to perform an electrolyte evaluation and a complete blood count. FA returned to Respondent on March 15, 2006 apparently feeling better, but Respondent's chart contains limited documentation and no discussion of anti-coagulation. FA had a follow-up appointment with Respondent on March 20, 2006 and he recorded her INR at 6.9 and continued Coumadin at a reduced dose. Respondent did not mention holding the dose, but did mention FA's blood pressure was a problem. However, Respondent failed to record a blood pressure reading to support this finding. FA saw Respondent on April 11, 2006 for a follow-up appointment for hypertension and Respondent diagnosed dysuria without a description or work-up. Respondent also diagnosed pulmonary infarction and thrombocytopenia with no discussion.

13. The standard of care requires a physician to administer Heparin until the patient is adequately anti-coagulated with Coumadin and to hold Coumadin when the patient's level is 6.9.

14. Respondent deviated from the standard of care by failing to administer Heparin to FA until she was adequately anti-coagulated with Coumadin and by failing to hold FA's Coumadin when her level was 6.9.

15. Poorly managed Coumadin in the setting of pulmonary embolism and inadequate treatment of dehydration caused by food poisoning could have caused permanent damage to FA's lungs, brain, kidney, and liver and could have resulted in her death.

16. Based upon the Chief Medical Consultant's review of the case involving FA, Board Staff randomly selected two more patient charts for review.

17. Respondent provided care to a seventy-one year old male patient ("MCM") from May 2000 until June 2006. MCM had hypertension and prostate cancer that was diagnosed in 1997 and treated with Lupron and seed implants. Respondent's progress notes were in a pre-printed format with areas to write in the chief complaint, history, physical examination,

diagnosis/management options and plan. Respondent's notations for each visit with MCM were few – the entire history noted in the first visit is "c/o regular visit/PSA. I. Hypertension II. Prostate CA III. Hyperlipidemia." On subsequent visits MCM had hemoccult positive stools and elevated liver functions that Respondent failed to address with colonoscopy or barium enema with flexible sigmoidoscopy. Respondent ignored MCM's health maintenance issues and inadequately managed his hypertension.

18. The standard of care requires a physician to perform routine health maintenance, such as rectal examinations; to adequately work-up rectal bleeding by performing a colonoscopy or barium enema with a flexible sigmoidoscopy; and to perform routine prostate examinations in patients with prostate carcinoma.

19. Respondent deviated from the standard of care because he failed to provide MCM with routine health maintenance, including rectal examinations; because he failed to adequately work-up MCM's hemoccult positive stool or bleeding; and because he failed to perform routine prostate examinations of MCM.

20. Inadequate health maintenance could delay a diagnosis of colon or prostate cancer.

21. KS, a fifty-five year-old male with coronary artery disease and a history of rectal bleeding, presented to Respondent complaining of acute severe headache. Respondent did not perform and/or document a neurologic examination of KS. Respondent diagnosed KS with migraines and treated him with a variety of medications. Respondent saw KS in follow-up of migraine and polyuria and polydipsia. Respondent did not perform a prostate examination, yet he diagnosed KS with prostatic enlargement.

22. KS saw Respondent multiple times for migraine and depression from June 2003 through February 2004. On February 5, 2005 Respondent diagnosed KS with attention deficit disorder and referred him to a psychiatrist. At a May 16, 2006 visit Respondent noted KS had

abnormal eye movements and on June 23, 2006 saw him for pre-operative clearance for eye surgery. Respondent noted an abnormal EKG and requested a cardiology consultation. KS was hospitalized from July 11, 2006 through July 15, 2006 by another physician who believed he had sustained a reversible ischemic neurologic deficit. During his hospitalization KS was noted to be aspirating and required PEG tube placement. Respondent saw KS on August 2, 2006, again to clear him for eye surgery. Respondent did not document KS's recent hospitalization or need for treatment of elevated cholesterol and tight control of blood pressure as recommended in a neurology consult obtained during KS's hospitalization. KS went on to have a stroke and hemiplegia.

23. The standard of care requires a physician to perform routine health maintenance; to adequately evaluate a patient who presents with a history of rectal bleeding; to treat a patient's elevated cholesterol; and to control a patient's blood pressure.

24. Respondent deviated from the standard of care by failing perform routine health maintenance, such as hemoccult testing for KS; by failing to work-up hemoccult positive stool or rectal bleeding; by failing to treat KS's elevated cholesterol; and by failing to control KS's blood pressure.

25. KS had a neurologic episode in July 2006 that may have been prevented if his blood pressure and cholesterol had been tightly controlled.

26. A physician is required to maintain adequate legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records for FA, MCM, and KS were inadequate as described above.

27. During the review of case number MD-06-0340A a concern was raised about Respondent's ability to safely engage in the practice of medicine. In order to assess Respondent's competency the Executive Director, on October 26, 2006, issued an Interim Order requiring Respondent to present for an evaluation at the Physician Assessment and Clinical Education Program ("PACE") within thirty days of the date of the Order. Respondent was due to present to PACE not later than November 26, 2006. On November 27, 2006 PACE notified Board Staff that Respondent had informed them he would not be participating in the evaluation.

28. At some point, Board Staff was informed that Respondent is or may be physically unable to safely engage in the practice of medicine due to serious health concerns.

29. On November 30, 2006 the Board issued Interim Findings of Fact and Conclusions of Law under which the Board concluded that Respondent had violated A.R.S. § 32-1401(27)(e) (failing or refusing to maintain adequate records on a patient), 32-1401(27)(q) (any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public), 32-1401(27)(r) (violating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director), 32-1401(27)(ll) (conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient), and A.R.S. § 32-1451(A) (physically unable safely to engage in the practice of medicine). The Board concluded that emergency action was required under A.R.S. § 32-1451(D), and ordered that Respondent's license be summarily suspended.[1]

30. On December 21, 2006 the Board issued a Notice of Hearing setting this matter for formal administrative hearing before the Office of Administrative Hearings, an independent state agency. The Board incorporated its Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License by reference into the Notice of Hearing.

[1] At hearing, the Board withdrew its allegation regarding A.R.S. § 32-1451(A).

CONCLUSIONS OF LAW

1. In this proceeding, the Board bears the burden to prove, by a preponderance of the evidence, that Respondent engaged in unprofessional conduct as defined in A.R.S. § 32-1401(27)(e), (q), (r), and/or (ll), and that he is subject to disciplinary action pursuant to A.R.S. § 32-1451. *See* A.A.C. R2-19-119.

2. A preponderance of the evidence is "such proof as convinces the trier of fact that the contention is more probably true than not." Morris K. Udall, Arizona Law of Evidence § 5 (1960).

3. Based on the evidence presented the Board sustained its burden of proof as to each of Respondent's alleged violations of A.R.S. § 32-1401(27).

4. A physician engages in unprofessional conduct if the physician fails or refuses to maintain adequate records on a patient. A.R.S. § 32-1401(27)(e).

5. Respondent failed to maintain adequate records for patients RR, FA, MCM, and KS. Therefore, Respondent violated A.R.S. § 32-1401(27)(e).

6. A physician engages in unprofessional conduct if the physician engages in any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public. A.R.S. § 32-1401(27)(q).

7. Respondent failed to adhere to the relevant standards of care in his treatment of RR, FA, MCM, and KS and such failure was either harmful or potentially harmful to the health of those patients. Therefore, Respondent violated A.R.S. § 32-1401(27)(q).

8. A physician engages in unprofessional conduct if the physician violates a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director. A.R.S. § 32-1401(27)(r).

9. Respondent violated the Order issued by the Board's executive director that he attend a PACE evaluation. Therefore, Respondent violated A.R.S. § 32-1401(27)(r).

10. A physician engages in unprofessional conduct if the physician engages in conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient. A.R.S. § 32-1401(27)(ll).

11. Respondent repeatedly failed to adhere to professional standards of care in his treatment of RR, FA, MCM, and KS and such failures were either harmful or potentially harmful to the health of those patients. Therefore, Respondent violated A.R.S. § 32-1401(27)(ll).

12. A.R.S. § 32-1451(M) provides:

> Any doctor of medicine who after a formal hearing is found by the board to be guilty of unprofessional conduct, to be mentally or physically unable safely to engage in the practice of medicine or to be medically incompetent is subject to censure, probation as provided in this section, suspension of license or revocation of license or any combination of these, including a stay of action, and for a period of time or permanently and under conditions as the board deems appropriate for the protection of the public health and safety and just in the circumstance. The board may charge the costs of formal hearings to the licensee who it finds to be in violation of this chapter.

13. Based on the foregoing statute, Respondent is subject to disciplinary action because he is found to have engaged in unprofessional conduct based on his violations of A.R.S. § 32-1401(27)(e), (q), (r), and (ll).

14. The State requested Respondent's license be revoked. Based upon Respondent's demonstrated violations of A.R.S. § 32-1401(27) and his decision to stop practicing medicine (as reflected in the stipulation between the parties) the ALJ concluded that revocation of Respondent's license was the proper disciplinary action.

ORDER

Based upon the Findings of Fact and Conclusions of Law as adopted, the Board hereby enters the following Order:

In view of the foregoing, Respondent's license No. 10262 for the practice of allopathic medicine in the State of Arizona is revoked on the effective date of this Order and Respondent shall return his wallet card and certificate of licensure to the Board.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review by filing a petition with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09. The petition must set forth legally sufficient reasons for granting a rehearing. A.C.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

Dated this 13 day of April, 2007.

ARIZONA MEDICAL BOARD

(SEAL)

By: _____
Timothy C. Miller, J.D.
Executive Director

Original of the foregoing filed this 13th day of April, 2007, with:

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